Chapter 14

Parity in the Federal Employees Health Benefits Program: An Overview*

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Introduction

The promotion and passage of mental health parity has recently been one of the top legislative and policy priorities among individuals with mental disorders and those who advocate for their interests (Mental Health Liaison Group, 2002a). Parity, which in its most basic form is a call for equal benefit coverage for mental and general medical disorders, has been described as a "step in the right direction" (Frank, et al., 2001) or a "sequential step" (Hennessy and Goldman, 2001) toward the larger goal of achieving fair access to quality treatment for mental disorders. Given that insurance parity is consistent with their broader objective of reducing discrimination toward individuals with mental illness, it is not surprising that mental health advocacy organizations support parity almost universally (Mental Health Liaison Group, 2002b).

Over the past decade, the efforts of individuals and advocacy groups have contributed to the enactment of 33 State parity laws as well as a Federal law mandating partial parity (National Advisory Mental Health Council, 2000). However, by fall 2003, the goal of a national law ensuring full parity for mental health benefits relative to coverage for general medical care has remained elusive. Despite substantial support in both houses of the U.S. Congress for a bill that would provide full parity and the endorsement by President Bush of some extension of the parity law, opposition from several key interest groups and legislators has prevented its passage.

Interestingly, organizations pushing for an expanded Federal mental health parity law have attempted to draw support for their position from the U.S. Office of Personnel Management's (OPM's) implementation of full mental health (and substance abuse) parity within the Federal Employees Health Benefits (FEHB) program beginning in 2001 (Office of Personnel Management, 1999). In arriving at its decision to mandate parity for health plans participating in FEHB, the administration and OPM were informed by research produced by the National Institute of Mental Health (NIMH) and the Substance Abuse and Mental Health Services Administration (SAMHSA), both agencies of the U.S. Department of Health and Human Services (DHHS) (National Advisory Mental Health Council, 2000; SAMHSA, 1998). It was fairly logical that, given this historic policy change, OPM chose to partner with DHHS in conducting a comprehensive evaluation of the impact of a parity mandate on stakeholders, most notably the approximately 8.5 million FEHB enrollees.

The purpose of this chapter is to provide an overview of parity within the FEHB program. Following a brief description of the evolution of parity more broadly, we outline the FEHB parity policy and summarize the design of the FEHB parity evaluation. Then we present initial information on nominal benefit changes pre- and postparity among health plans participating in FEHB. The chapter concludes with a brief discussion of how information generated from the evaluation may be useful in advancing our understanding of parity's effects on relevant stakeholders, including beneficiaries, health plans, providers, and purchasers of mental health services.

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Evolution of Mental Health Parity

Although parity laws have been enacted only over the past decade, the concept of parity has been discussed in some form since the 1960s. While parity regulations can take many forms, the core concept is that insurance for behavioral health benefits should be offered at the same level as coverage for other medical conditions. Historically, behavioral health coverage has been more limited than coverage for other medical services. Health plans commonly require higher copayments and more stringent limits on inpatient hospital days and outpatient visits for behavioral health treatment. Plans have also limited mental health and substance abuse (MH/SA) coverage through the use of annual and lifetime dollar limits.

Frank and colleagues (2001) trace the economic and political factors that have influenced arguments on both sides of the parity debate. They note that the advent of managed care and its demonstrated ability to control mental health costs has tended to neutralize concerns that the introduction of parity would exacerbate moral hazard problems. "Moral hazard" refers to the increase in use of services that accompanies the provision of insurance when an individual no longer assumes the full costs of care. Research suggests that consumers are more sensitive to a reduction in the price of outpatient mental health services than other health services under traditional indemnity insurance policies. The RAND Health Insurance Experiment (HIE) demonstrated that increased use of services by consumers in response to decreased out-of-pocket costs was twice as great under fee-for-service (FFS) insurance arrangements for outpatient mental health services compared with ambulatory health services as a whole (Manning et al., 1989). This research prompted the concern that expanded behavioral health benefits would be too expensive and an inefficient use of health care resources.

Under managed care, insurers can control costs with tools other than benefit design, including network design, utilization management, and provider payment methods. As a result, managed care attenuates the moral hazard problem. Benefits can be expanded under parity without worrying about high costs because health plans can control use in ways other than restricting benefits. Recent policy research suggests that benefit expansions can be implemented without much of a cost impact in a managed care setting (Frank et al., 2001; National Advisory Mental Health Council, 2000; Sturm, 1997). In fact, in cases studies involving Pacific Bell (Goldman, et al., 1998), the Ohio State employee insurance program (Sturm and McCulloch, 1998), and the Massachusetts State employee insurance program (Huskamp, 1999; Ma and McGuire, 1998), researchers found evidence of cost savings when benefit expansion was implemented alongside a carveout. A recent analysis of a large employer plan that began contracting with a behavioral health vendor after a State mental health parity law was enacted found that its MH/SA treatment costs declined nearly 40 percent (Zuvekas, 2001). Thus, widespread application of managed care practices to mental health services has largely paved the way for the adoption of State parity laws, as well as of the 1996 Federal partial parity law, by demonstrating the relative affordability of mental health benefit expansions when they occur within a managed care framework (National Advisory Mental Health Council, 2000).

Unfortunately, Frank and colleagues (2001) also warn that parity regulations have the potential to exacerbate the problem of adverse selection under managed care. Mental health is an area in which incentives to avoid costly enrollees appear to exert a particularly strong impact. In a market with competing health plans, individuals in need of more services gravitate toward plans with the most generous benefits. To avoid sicker, more costly enrollees, plans may limit certain types of benefits that would be attractive to such individuals. For example, plans could set low limits on hospital days and outpatient visits to send the message to consumers with relatively high levels of expected mental health service use that they may be better off choosing another plan. Thus, adverse selection refers to the inefficiently low levels of coverage for behavioral health that may result if, in an effort to control costs, health plans compete to enroll people considered to be good risks and avoid caring for high-cost, persistently ill patients.

Under traditional FFS insurance arrangements, parity helps to mitigate the adverse selection problem by increasing the generosity of mental health benefits. However, under managed care, health plans can now employ a whole new set of tools for controlling use of mental health services regardless of "nominal benefit design." These managed care cost control strategies do not lend themselves to regulatory monitoring and can be used to select healthier patients. As a result, economic theory suggests that policymakers need to be particularly vigilant to avert exacerbating adverse selection under managed care even when more comprehensive parity policies are in place. Therefore, parity is unlikely to

be as costly today and, thus, is more politically feasible. However, adverse selection constitutes more of a hidden threat in a managed care environment.

Parity in the FEHB Program

The FEHB program has been characterized as the largest employer-sponsored health benefit system in the United States. Nearly 200 distinct health plans participate in the FEHB program, offering health insurance coverage to roughly 8.5 million beneficiaries. Of these beneficiaries, approximately 25 percent are current Federal employees, 25 percent are annuitants or retirees from the Federal Government, and 50 percent are spouses or dependents of current or retired Federal employees. Given the number of individuals affected, it is not surprising that some saw OPM's decision to implement full parity for MH/SA benefits as an "historic undertaking that breaks new ground for employer-sponsored health care programs" (Washington Business Group on Health, 2000).

Managed care has contributed substantially to the re-introduction of parity for Federal employees and their dependents. Interestingly, Federal workers possessed a mental health parity benefit in the 1960s when then President Kennedy called on the Civil Service Commission (the predecessor to the OPM) to treat general medical and psychiatric conditions the same within the FEHB program (Frank et al., 2001). By the 1980s, however, expansion of FEHB to include more health plans led to competition that eroded the earlier parity benefit (Foote and Jones, 1999; Hustead, et al., 1985). For example, the cost of mental health services in the Blue Cross high option plan was two to three times higher than the Blue Cross standard option plan, even though there were only minor differences in the actuarial value of benefits.

Beginning in the 1990s, the FEHB mental health benefit gradually began to improve again with the abolition of lifetime and annual dollar benefit limits and the equalization of coverage for pharmacotherapy management for general medical versus mental disorders. These improvements provided a foundation for President Clinton's 1999 directive to OPM calling for full parity for both MH/SA benefits in the FEHB program by 2001.

Parity as defined by OPM is fairly inclusive, and means that a plan's coverage for MH/SA must be identical to its coverage for general medical care with regard to deductibles, coinsurance, copayments, and day and visit limitations (OPM, 2000). While plans retain a good deal of discretion in the design of their benefits, OPM's guidance to participating health plans strongly recommended that parity benefit proposals include "an appropriate care-management structure" (OPM, 2000). Such a structure could take various forms, including the use of managed behavioral health care organizations, gatekeeper referrals to network providers, authorized treatment plans, precertification of inpatient services, concurrent review, discharge planning, case management, retrospective review, and disease management programs. In providing guidance to the FEHB plans, OPM conveyed its belief based on research evidence that parity delivered under management could expand access to care with a minimal impact on cost.

Although no single parity benefit or standard exists, mainly because of differences among plans with regard to medical benefits, OPM outlined a number of general principles for the implementation of parity in the FEHB program. First, plans were instructed to cover clinically proven treatments for all mental illness and substance abuse conditions listed in the *Diagnostic and Statistical Manual,* 4th edition (DSM-IV) such that services for these conditions would be included in authorized treatment plans and meet medical necessity determination criteria. Second, although plans were expected to provide parity-level coverage for in-network facilities and providers, parity benefits were not expected for out-of-network coverage if reasonable standards for access to in-network providers and facilities were maintained. However, plans were encouraged strongly to keep out-of-network benefits for MH/SA at or near 2000 preparity levels. Finally, OPM emphasized its expectation that plans would work continually to increase access to network providers, thus giving enrollees an adequate selection of providers offering parity-level benefits. To date, plans have expressed few if any concerns regarding OPM's guidance around implementing MH/SA parity in the FEHB program.

Overview of the FEHB Parity Evaluation

In the spring of 2000, the DHHS partnered with the OPM to sponsor an evaluation of the implementation and impact of parity within the FEHB program. By the fall of that year, an evaluation contract had been awarded to a consortium of researchers led by Northrop Grumman Information Technology and including Harvard Medical School,

the RAND Corporation, the University of Maryland, and Westat. At the time this chapter is being written, the evaluation is roughly at midpoint, with a scheduled completion date of the fall of 2004.

The overall goal of the evaluation is to examine both the implementation of the parity requirement for FEHB plans and the impacts of parity on the plans and their beneficiaries (DHHS, 2001). As part of this goal, the evaluation has three primary objectives:

(1) To assess the degree to which the parity requirement affects benefit design and management; access to MH/SA services; use of MH/SA services; beneficiary, plan, and OPM costs; quality of MH/SA services; and provider awareness of the parity policy change.

(2) To examine the patterns in these effects across subgroups of plans, providers, and beneficiaries.

(3) To assess the interrelationships among changes in benefit design and management, costs, access, utilization, and quality.

The evaluation seeks to address a number of specific research questions concerning the implementation and impact of parity within the FEHB program. These key questions are outlined by domain in table 1. A variety of data sources and data collection methods, including the following, will be used to answer the array of research questions posed in the evaluation:

- *Nominal plan benefits*. Behavioral health, general medical, and pharmacy benefits offered by FEHB-participating health plans during the two years prior to parity (1999 and 2000) and the two years after parity (2001 and 2002) are being collected and analyzed using publicly available information posted on the OPM Web site. These data will be used to address questions in the Benefits domain.

- *Implementation plan reports*. All FEHB plans with more than 500 enrollees will report to OPM in 2002 and 2003 on their benefit design changes during the preceding year. These reports will describe plan policies and procedures regarding the delivery of MH/SA benefits and any changes plans have made in implementing the parity requirement. Information from the reports will be used to address research questions in the Benefits domain.

- *Site visits*. Site visits to eight FEHB plans have been conducted to examine changes in administrative, financial, and clinical management operations related to the implementation of parity. Information from these site visits will be used to address research questions in the Benefits, Cost, and Quality domains.

- *Enrollment and claims/encounter data.* Enrollment and claims/encounter data are being collected and analyzed from eight health plans on all health services (MH/SA, medical, pharmacy) provided to beneficiaries during the two years before and two years after parity implementation. These data are being compared with a national comparison group unaffected by the parity mandate to control for secular trends not associated with parity. Analysis of these data will be used to address research questions in the Cost, Access, Utilization, and Quality domains.

- *Provider focus groups.* Six provider focus groups were conducted to assess the perceptions and experiences of these individuals regarding their perspectives on the implementation of parity for Federal employees. These interviews explored research questions in the Access, Quality, and Awareness domains.

The evaluation design is quasi-experimental. As noted above, nominal plan benefits information, enrollment, and claims/encounter data are being examined both before and after parity to assess possible changes in benefits, cost, access, utilization, quality of, and satisfaction with mental health and substance abuse services. In addition to these "pre-post" analyses, claims and encounter data will be compared with a matched national non-FEHB comparison group. By comparing FEHB enrollees experiencing parity with a non-FEHB sample of plans not subject to parity regulations, it may be possible to determine the role of parity separate from other factors affecting cost, access, and utilization of MH/SA services during the study period. For example, the implementation of various State parity laws and the potential for increased use of MH/SA services as a consequence of the events of September 11, 2001, may complicate the interpretation of results. The use of a comparison group should reduce this con-

Table 1. Key domains in the FEHB program parity evaluation

Benefits

How have the following changed as a result of the parity requirement?

- The design of mental health and substance abuse (MH/SA) benefits offered by FEHB plans
- The policies and procedures related to the management of the MH/SA benefits offered by FEHB plans
- The structure and management of physical health benefits offered by FEHB plans

Cost

- Have aggregate and per-enrollee costs for MH/SA services within select FEHB plans changed after implementation of parity? How do these changes compare with secular trends?
- Have out-of-pocket costs to beneficiaries using MH/SA services (e.g., deductibles, copayments, and out-of-pocket limits) within select FEHB plans changed after implementation of parity? How do these changes compare with secular trends?
- Have FEHB plans incurred additional administrative costs attributable to the parity requirement?
- Has the Federal Government incurred additional expenses (e.g., premium costs) attributable to the parity requirement?
- Within select FEHB plans, is there evidence of either adverse or favorable risk selection among new enrollees or those disenrolling after the implementation of parity?

Access

- What are the patterns of access to MH/SA services within select FEHB plans before and after the implementation of parity? How do any changes compare with secular trends?
- Do these patterns of access differ by use of in- vs. out-of-network providers, type of user, type of service, level of service, or type of condition? How do these patterns compare with secular trends?
- Are beneficiaries in select FEHB plans aware of any changes in MH/SA benefits related to the parity requirement?
- Do beneficiaries in select FEHB plans identify an unmet need for MH/SA services? How does any unmet need compare with secular trends?

Utilization

- What are the patterns of service utilization for MH/SA services within select FEHB plans before and after implementation of parity? How do these changes compare with secular trends?
- Do these patterns of service utilization differ by use of in- vs. out-of-network providers, type of user, type of service, level of service, or type of condition? How do these patterns compare with secular trends?

Quality

- What types of quality assurance strategies have FEHB plans implemented as a result of the parity requirement (e.g., utilization review, case management, disease management protocols, patient care teams, outcomes monitoring)?
- Do FEHB plans use any evidence-based practice guidelines for the treatment of mental health, substance abuse conditions, or any other conditions? If so, how well do the patterns of care for MH/SA or other conditions (as evidenced in administrative claims/encounter data) reflect adherence to proposed guidelines? How do these patterns compare with secular trends?
- Are there any changes in either the use of guidelines or adherence to guidelines that are related to the implementation of parity? If so, how do these changes compare with secular trends?

Awareness/Satisfaction

- Are beneficiaries in select FEHB plans aware of any changes in MH/SA benefits related to the parity requirement, and how satisfied are they with the changes?
- Are beneficiaries who have used or attempted to use MH/SA benefits in select FEHB plans satisfied with their experiences?
- Are providers aware of any changes in the MH/SA benefits related to the parity requirement?

cern somewhat. Site visits and provider focus groups will provide additional information on how various stakeholders are affected by this important policy change.

This parity evaluation design is limited in several ways. The nature of the policy change (i.e., requiring parity within all plans participating in the FEHB program) precluded the use of a randomized study design. In addition, resource limitations necessitated that archival data activities be focused on only eight health plans, possibly limiting the generalizability of evaluation findings. Moreover, beneficiary survey data were not collected, limiting conclusions that might be drawn about the impact of the parity policy on those using MH/SA services. Despite these limitations, the evaluation represents a carefully designed research effort that is likely to contribute substantially to our understanding of parity's effect on the organization, financing, and delivery of MH/SA services.

Initial Information on Benefit Changes

The results from most of the components of this evaluation are not yet complete. However, we can present initial information on how plans have responded to parity using nominal benefit design information. This descriptive analysis constitutes a first step toward understanding how parity affects the health care of FEHB beneficiaries.

As noted above, FEHB participating health plans changed their benefit packages substantially to comply with the parity mandate. Prior to the mandate, most FEHB plans placed special limits on MH/SA coverage. Restrictions took the form of higher beneficiary cost-sharing, inpatient day limits, outpatient visit limits, and separate annual and per admission deductibles for MH/SA services. In addition, some plans imposed annual and lifetime spending caps on substance abuse services. These restrictions meant that enrollees shouldered a higher portion of the costs of treating mental and substance abuse disorders compared with treating general medical conditions.

As a consumer choice program, the FEHB commits to offering beneficiaries a number of health plan options in all areas where Federal employees reside. Three types of health plan choices are available—FFS plans, community-rated health maintenance organizations (HMOs), and a small number of experience-rated HMOs. The FFS plans are available nationally,[1] and the Blue Cross Blue Shield Federal Employees Plan (FEP) is by far the largest, with a total enrollment of more than 3.7 million in 2001. Community-rated and experience-rated HMOs are offered at the regional, State, or county level and tend to be much smaller, with average enrollments of 10,774 and 23,282, respectively, in 2001.

Most FFS plans contain a number of management features, such as preferred provider and member hospital options, that distinguish them from traditional indemnity insurance products, and some administrative controls on services use, such as prior authorization. For FFS plans and experience-rated HMOs, premiums are based on prior year health plan enrollee spending. For community-rated HMOs, the annual process of setting premiums is based on insurance rates of non-FEHB health plans in the communities served by the FEHB. Throughout this analysis, we examine aggregate benefit change under parity as well as benefit change within each of these three categories of plans.

Data

We used publicly available data on FEHB plans to look at benefit change.[2] We examined data from 161 health plans that participated continuously in FEHB during the two years prior to the parity mandate (1999 and 2000) and the first year of parity implementation (2001). Thus plans that exited or entered FEHB after 1999 are excluded from this analysis. We also excluded plans with fewer than 500 enrollees in 1999. After removing plans with very low enrollment and plans not continuously enrolled during our study period, the remaining 161 plans still captured benefit data for 94 percent of FEHB beneficiaries.

Of these, 12 are FFS plans,[3] 137 are community-rated HMOs, and 12 are experience-rated HMOs. However, enrollment is heavily skewed toward the FFS plans. Seventy-seven percent of beneficiaries

[1] Many of the national fee-for-service plans are open to all FEHB beneficiaries; however, six are limited to employees, retirees, and dependents within specific groups, such as the Foreign Service.

[2] Data on benefits offered by FEHB-participating plans are available through the Office of Personnel Management Web site at www.opm.com/insure.

[3] Thirteen FFS national plans participate in FEHB; however, the Panama Canal Area Benefit Plan is excluded from this analysis. Three of the remaining twelve plans offer separate high and standard benefit options to enrollees (Blue Cross Blue Shield, Postmasters Benefit, and Mailhandlers Benefit). For the purpose of this analysis, high and standard benefit options will be counted as separate plan benefit designs. Therefore, results in descriptive tables 2 through 6 are calculated with $n = 15$ for FFS plans and $n = 164$ for all plans.

are enrolled in these plans, with only 20 percent in the community-rated HMOs and three percent in the experience-rated HMOs. The benefit design information collected from these plans includes beneficiary cost-sharing; deductibles; and day, visit, and dollar limits for general medical and MH/SA services.

Preparity FEHB Plan Benefits

MH/SA benefits offered by FEHB plans were substantially less generous than general medical benefits in the two years before the parity mandate took effect. We found that in 1999 and 2000, 98 percent of plans contained at least one design feature more restrictive for MH/SA benefits than for medical benefits. Such restrictions on preparity MH/SA benefits in FEHB resemble the restrictions placed on most health plans nationwide. For example, a 2000 General Accounting Office (GAO) employer survey examining the effects of the Federal partial parity law in 26 States found that at least 87 percent of employer plans contained at least one more restrictive mental health benefit design feature (GAO, 2000). The GAO did not examine the prevalence of more restrictive substance abuse coverage because these benefits fell outside the scope of the Federal law.

Prior to parity, the majority of FEHB plans contained annual service limitations on inpatient days and outpatient visits for behavioral health. In contrast, no FEHB plans restricted inpatient days or outpatient visits for general medical coverage. Table 2 summarizes the preparity service restrictions used by FFS, community-rated, and experience-rated FEHB plans. During 1999 and 2000, plans limited outpatient mental heath care to an average of 26 visits annually and inpatient mental health care to an average of 34 days. For substance abuse coverage in the two years prior to parity, annual outpatient limits averaged 27 visits. Limits on inpatient substance abuse treatment averaged 26 days in 1999 and 28 days in 2000. While there is some variation by plan type (for example, mental health day and visit limits were slightly higher in FFS plans), these data show that such restrictions were widespread. In fact, only nine percent of plans placed no service limits on MH/SA benefits in 1999 and 2000.

Prior to parity, some health plans included annual and lifetime dollar limits on substance abuse care as design features. Under the 1996 Federal partial parity law, health plans are barred from using annual or lifetime dollar limits to control the use of mental health services unless equal dollar limits are also placed on other medical services. Federal parity in dollar limits does not yet extend to substance abuse coverage. As table 3 indicates, nine percent of FEHB plans placed annual dollar limits and 15 percent of plans placed lifetime limits on substance abuse services in 1999. None of these plans placed equivalent dollar limits on other medical services. These limits tended to be much more common among national FFS plans than either community-rated or experience-rated HMOs. This may be due to the fact that FFS plans are more reliant than managed care plans on benefit design restrictions for controlling use. Theoretically, managed care organizations can control spending through a range of other administrative and provider reimbursement techniques. In 1999, annual dollar limits on substance abuse coverage ranged from $3,000 to $50,000 and lifetime limits most often took the form of two 28-day inpatient stays—a traditional approach for treating addiction. Finally, many FEHB plans maintained higher cost-sharing levels for MH/SA services than for general medical health care prior to the parity mandate. For example, in 1999, 70 percent of plans required higher cost-sharing for outpatient behavioral health services, and 29 percent required higher cost-sharing for inpatient behavioral health services.[4] In 2000, outpatient cost-sharing was higher for 62 percent of plans and inpatient cost-sharing was higher for 28 percent of plans.

Implementing Parity: Changes in Benefit Design

OPM began implementing parity in the FEHB in January 2001. All plans within our study population appear to be complying with this parity mandate. This finding is noteworthy given the compliance problems that have occurred in the context of the Federal partial parity law. A year and a half after the U.S. Congress implemented its partial parity law, the GAO found that 14 percent of plans were not compliant (GAO, 2000). In contrast, plans within FEHB appear to have removed all inpatient day limits, outpatient visit limits, and dollar limits, and cost-sharing for behavioral health appears to be on par with cost-sharing for general medical care.

[4] For a number of additional plans, it is unclear whether the MH/SA cost-sharing burden is higher because these plans required a dollar copayment for general medical services and a percentage coinsurance rate for MH/SA services; therefore, these cost-sharing requirements are not directly comparable.

Table 2. Service limits preparity (1999 and 2000)

	Mean Limit		Median Limit	
	1999	2000	1999	2000
Inpatient Mental Health Day Limits				
All plans (n = 164)*	34	34	30	30
FFS plans (n = 15)*	57	53	50	45
Community-rated plans (n = 137)	31	32	30	30
Experience-rated plans (n = 12)	33	28	30	30
Outpatient Mental Health Visit Limits				
All plans (n = 164)*	26	26	25	25
FFS plans (n = 15)*	30	27	30	25
Community-rated plans (n = 137)	25	26	20	20
Experience-rated plans (n = 12)	29	26	30	30
Inpatient Substance Abuse Day Limits				
All Plans (n = 164)*	26	28	30	30
FFS plans (n = 15)*	22	24	20	20
Community-rated plans (n = 137)	27	29	30	30
Experience-rated plans (n = 12)	26	28	30	30
Outpatient Substance Abuse Visit Limits				
All plans (n = 164)*	27	27	22	27
FFS plans (n = 15)*	17	16	20	20
Community-rated plans (n = 137)	28	29	25	30
Experience-rated plans (n = 12)	24	27	25	30

* Thirteen FFS national plans participate in FEHB; however, the Panama Canal Area Benefit Plan is excluded from this analysis. Three of the remaining twelve plans offer separate high and standard benefit options to enrollees (Blue Cross Blue Shield Plan, Postmasters Benefit Plan, and Mailhandlers Benefit Plan). For the purpose of this analysis, high and standard benefit options are counted as separate plan benefit designs. Therefore, results in this table are calculated with n = 15 for FFS plans and n = 164 for all plans.

Table 3. Annual and lifetime dollar limits on substance abuse benefits preparity

	Annual Dollar Limits (%)		Lifetime Dollar Limits (%)	
	1999	2000	1999	2000
All plans (n = 164)*	9%	9%	15%	14%
FFS plans (n = 15)*	47%	53%	60%	53%
Community-rated plans (n = 137)	4%	4%	10%	10%
Experience-rated plans (n = 12)	8%	8%	8%	8%

* Thirteen FFS national plans participate in FEHB; however, the Panama Canal Area Benefit Plan is excluded from this analysis. Three of the remaining twelve plans offer separate high and standard benefit options to enrollees (Blue Cross Blue Shield Plan, Postmasters Benefit Plan, and Mailhandlers Benefit Plan). For the purpose of this analysis, high and standard benefit options are counted as separate plan benefit designs. Therefore, results in this table are calculated with n = 15 for FFS plans and n = 164 for all plans.

Table 4 illustrates how beneficiary cost-sharing requirements changed under parity. Some FEHB plans require beneficiaries to pay a fixed copayment for treatment, while other plans charge coinsurance rates at a certain percentage of total treatment costs. After parity, the median copayment required by FEHB plans fell from $20 to $10 per visit for outpatient MH/SA services. Similarly, the outpatient median coinsurance rates charged to beneficiaries dropped from 50 percent in 1999 to 15 percent in 2001. For inpatient care, median MH/SA copayments dropped from $25 in 1999 to zero under the parity mandate, while median coinsurance rates dropped from 20 percent to 10 percent.

In theory, plans might try to comply by reducing the generosity of general medical benefits rather than increasing the generosity of behavioral health benefits. For the most part, this is not the case in FEHB. Table 5 shows that both outpatient and inpatient cost-sharing for general medical care remained relatively stable both across all plans and among FFS, community-rated, and experience-

Table 4. Change in behavioral health cost-sharing

(Median values for plans with cost-sharing greater than zero)	Median Copayment			Median Coinsurance Rate		
	1999	2000	2001	1999	2000	2001
Inpatient Mental Health Coverage						
All plans (n = 164)*	25	25	0	20%	20%	10%
FFS plans (n = 15)*	0	0	0	30%	30%	10%
Community-rated plans (n = 137)	25	25	0	20%	20%	15%
Experience-rated plans (n = 12)	50	50	0	20%	20%	0%
Outpatient Mental Health Coverage						
All plans (n = 164)*	20	20	10	50%	50%	15%
FFS plans (n = 15)*	17.5	15	15	50%	40%	10%
Community-rated plans (n = 137)	20	20	10	50%	50%	0%
Experience-rated plans (n = 12)	15	15	10	50%	50%	20%
Inpatient Substance Abuse Coverage						
All plans (n = 164)*	25	25	0	20%	20%	10%
FFS plans (n = 15)*	0	0	0	30%	30%	10%
Community-rated plans (n = 137)	25	25	0	20%	20%	15%
Experience-rated plans (n = 12)	50	50	0	20%	20%	0%
Outpatient Substance Abuse Coverage						
All plans (n = 164)*	20	20	10	50%	40%	15%
FFS plans (n = 15)*	17.5	15	15	35%	30%	10%
Community-rated plans (n = 137)	20	20	10	50%	35%	0%
Experience-rated plans (n = 12)	17.5	17.5	10	50%	50%	20%

* Thirteen FFS national plans participate in FEHB; however, the Panama Canal Area Benefit Plan is excluded from this analysis. Three of the remaining twelve plans offer separate high and standard benefit options to enrollees (Blue Cross Blue Shield Plan, Postmasters Benefit Plan, and Mailhandlers Benefit Plan). For the purpose of this analysis, high and standard benefit options are counted as separate plan benefit designs. Therefore, results in this table are calculated with n = 15 for FFS plans and n = 164 for all plans.

rated plans. Copayment requirements for outpatient medical care rose slightly across the board, and community-rated plans appear to have increased inpatient coinsurance rates somewhat. However, plans clearly did not respond to the mandate by simply reducing general medical benefits.

We did find some evidence that plans complied with parity by redefining the nature of their medical benefit. For example, we identified 39 plans (24 percent) that began distinguishing in 2001 between general medical cost-sharing for a medical primary care visit and for a medical specialist visit, with a higher cost-sharing dollar amount attached to medical specialist care. To comply with parity, these plans required beneficiaries to pay for behavioral health care at a rate equivalent to the higher medical specialist charge rather than the lower medical primary care charge. Whereas this benefit structure fully complies with the mandate, it suggests that some plans altered general medical coverage in response to parity.

Variation in Responses to Parity

In this section, we take a closer look at the benefit design of three FEHB health plans. Tables 6, 7, and 8 summarize benefit changes within a nationally available FFS plan, a community-rated HMO in California, and an experience-rated point of service (POS) plan in New York. The OPM allows some flexibility in plan benefit design, so there is no single FEHB benefit design package. Examination of these three benefit designs provides a more nuanced view of how plans have responded to parity.

Like the majority of national FFS plans available to FEHB beneficiaries, the health plan profiled in table 6 provides beneficiaries with both in-network and out-of-network options. In-network benefits restrict beneficiaries to a designated network of providers, while out-of-network benefits can be obtained from any provider. Given the greater flexibility of out-of-network benefits, a beneficiary choosing this option is normally expected to pay a larger portion of the total cost of care out-of-pocket. For exam-

Table 5. General medical cost sharing pre- and postparity

(Median values for plans with cost-sharing greater than zero)	Median Copayment			Median Coinsurance Rate		
	1999	2000	2001	1999	2000	2001
Inpatient General Medical Coverage						
All plans (n = 164)*	0	0	0	15%	15%	10%
FFS plans (n = 15)*	0	0	0	10%	10%	10%
Community-rated plans (n = 137)	0	0	0	0%	0%	20%
Experience-rated plans (n = 12)	0	0	0	20%	20%	20%
Outpatient General Medical Coverage						
All plans (n = 164)*	5	10	10	50%	50%	15%
FFS plans (n = 15)*	15	15	15	10%	10%	13%
Community-rated plans (n = 137)	5	10	10	0%	0%	0%
Experience-rated plans (n = 12)	5	10	10	20%	20%	20%

* Thirteen FFS national plans participate in FEHB; however, the Panama Canal Area Benefit Plan is excluded from this analysis. Three of the remaining twelve plans offer separate high and standard benefit options to enrollees (Blue Cross Blue Shield Plan, Postmasters Benefit Plan, and Mailhandlers Benefit Plan). For the purpose of this analysis, high and standard benefit options are counted as separate plan benefit designs. Therefore, results in this table are calculated with n = 15 for FFS plans and n = 164 for all plans.

Table 6. An FEHB fee-for-service national plan

	Preparity				Postparity	
	1999		2000		2001	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Outpatient medical cost sharing	$15	30%	$15	30%	$15	30%
Outpatient mental health cost sharing	50%	50%	30%	30%	$15	30%
Outpatient substance abuse cost sharing	50%	50%	30%	30%	$15	30%
Day limits on mental health inpatient care	45	45	45	45	0	45
Day limits on substance abuse inpatient care	45	45	45	45	0	45
Visit limits on mental health outpatient care	20	20	20	20	0	20
Visit limits on substance abuse outpatient care	20	20	20	20	0	20
Annual substance abuse dollar limit	0	0	0	0	0	0
Lifetime substance abuse dollar limit	0	0	0	0	0	0

Table 7. An FEHB community-related plan

	Preparity		Post-parity
	1999	2000	2001
Outpatient medical cost sharing	$5	$10	$10
Outpatient mental health cost sharing	$10	$5	$10
Outpatient substance abuse cost sharing	$5	$5	$10
Day limits on mental health inpatient care	45	45	0
Day limits on substance abuse inpatient care	45	45	0
Visit limits on mental health outpatient care	20	20	0
Visit limits on substance abuse outpatient care	20	20	0
Annual substance abuse dollar limit	0	0	0
Lifetime substance abuse dollar limit	0	0	0

Table 8. An FEHB experience-related plan

	Preparity		Post-parity
	1999	2000	2001
Outpatient medical cost sharing	$10	$10	$10
Outpatient mental health cost sharing	$10	$10	$10
Outpatient substance abuse cost sharing	$0	$0	$10
Day limits on mental health inpatient care	60	0	0
Day limits on substance abuse inpatient care	30	30	0
Visit limits on mental health outpatient care	30	0	0
Visit limits on substance abuse outpatient care	60	60	0
Annual substance abuse dollar limit	0	0	0
Lifetime substance abuse dollar limit	0	0	0

ple, in table 6 the in-network outpatient medical benefit entails only a $15 copayment, whereas the out-of-network medical benefit requires a beneficiary to pay 30 percent of the cost of treatment.

Prior to parity, most national FFS plans did not distinguish between in-network and out-of-network behavioral health benefits (although most distinguished between in-network and out-of-network benefits for general medical services). With parity implementation, these plans began differentiating between in-network and out-of-network behavioral health benefits, and the new out-of-network benefit design typically matched the more restrictive behavioral health benefit in place prior to the introduction of parity. This pattern is illustrated in table 6, where a much more generous in-network parity benefit is created in 2001, whereas the less generous out-of-network option exactly matches the 2000 behavioral health benefit. Like the 2000 benefit, MH/SA outpatient benefits are covered with a 30 percent cost-sharing requirement and a 20-day annual limit on covered visits through the 2001 out-of-network benefit option. Thus, enrollees benefit from parity only if they choose in-network benefits. The effect of this design change on beneficiaries' shifting use of in-network versus out-of-network benefits is not yet understood. Traditionally, community-rated and experience-rated HMOs have not offered an out-of-network benefit option. In theory, these plans could develop an out-of-network product in response to the parity mandate; however, such a trend is not observed in our data.

Several other benefit design choices are worth noting. Comparison of these three plans highlights some variation in the generosity of MH/SA benefits both within and across plans. For example, the experience-rated health plan profiled in table 8 eliminated mental health day and visit limits in the year prior to parity implementation. A number of plans appear to have begun altering their benefit packages to comply with parity in anticipation of implementation. Because the OPM announced parity in 1999 but did not implement it until 2001, early responses to parity among plans should be expected. However, anticipation responses will need to be examined closely in the broader evaluation to accurately measure the true effects of parity.

Finally, the language changes in the benefit brochures of these three plans postparity reflect an effort to apply a broader medical necessity criteria to the use of behavioral health benefits. For example, the preparity plan brochures for two of these plans state that care for psychiatric conditions that "in the judgment of plan doctors are not subject to significant improvement through relatively short-term treatment would be excluded from coverage." In 2001, however, coverage determinations were based solely on the same medical necessity criteria for us-

ers of both general medical and behavioral health services. Such utilization management changes may reflect a broader application of parity beyond mandated changes in nominal benefits. This issue warrants further examination.

Alternative Plan Responses to Parity

Plans might respond to parity beyond benefit change in a variety of ways that we are unable to evaluate through an analysis of benefit design data. For example, plans concerned about rising costs under parity might respond by beginning to contract with managed behavioral health care organizations or by adjusting their risk-sharing relationship under existing carve-out contracts. Or plans may change the structure of provider reimbursement, adjust provider networks, or alter administrative mechanisms for managing care. We will know much more about these issues when the full evaluation is completed.

Conclusions

In this chapter, we outlined the structure of the Federal evaluation of behavioral health parity in the FEHB and reported initial information on how plan benefits have changed in response to the mandate. Although FEHB plans differed in the combination of benefit design features used to control behavioral health spending, special limits on coverage for these services were widespread in the two years prior to the implementation of parity. Ninety-eight percent of plans included at least one design feature that was more restrictive for MH/SA services than general medical services. Some plans required higher beneficiary cost-sharing for behavioral health, while others used tight service limits on inpatients days and outpatient visits. In addition, a number of plans required beneficiaries to pay separate MH/SA deductibles, whereas others placed annual and lifetime restrictions on total spending for substance abuse treatment.

From evaluation of the 1996 Federal partial parity law, we know that benefit design features used to expand access to behavioral health services can be circumvented to a certain extent. The GAO found that when the Federal Government prohibited the use of annual and dollar limitations on mental health care, health plans responded by increasing cost-sharing or switching to annual service limits on the number of inpatient days or outpatient visits (GAO, 2000a). By choosing to extend parity to a broader range of benefit design features, the FE-HB mandate effectively prevented these types of benefit shifts and created an opportunity to evaluate the impact of full parity.

Our use of benefit design data to evaluate parity in the FEHB has some important limitations. As noted above, small plans and plans that exited the FEHB during this study period or began participating after 1999 are excluded from this analysis. We also are unable to examine some aspects of benefit design from these data. For example, our data exclude information on the coverage of certain services, such as partial hospitalization. Finally, since we are unable to determine how plan benefits might have changed during this period in the absence of the mandate, we cannot state conclusively that these benefit design changes are fully attributable to parity.

With the completion of the parity evaluation in late 2004, researchers will be better able to gauge the broader effects of parity on both plan behavior and the health of beneficiaries. The various evaluation research strategies outlined in this chapter will provide policymakers with a better understanding of how behavioral health parity affects the quality, cost, access, and efficiency of the care available to Federal employees. In addition, we are collecting and analyzing information to help gauge the impact of parity on providers and purchasers of mental health services. The research domains outlined in table 1 constitute the key elements of the evaluation's broad analytic approach. They include an evaluation of benefits, costs, utilization, access, quality, and, to a lesser extent, provider awareness. This initial examination of change in benefit design constitutes an important first step toward understanding the implementation of parity in FEHB.

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